SPECIAL ARTICLE

Health In The Era of Sustainable Development

K Srinath Reddy

Whether it is continued commitment to the MDG agenda, initiation of effective action on new elements like non-communicable diseases and mental health or earnestly implementing a well planned programme of universal health coverage, India's health priorities resonate well with the SDG targets. We need to gear up the performance of our health system to reach those targets. Equally important, we need to work towards greater policy coherence in harmonising actions across the different development sectors, so that they enable and not erode each other. Only then can we create a healthy future for ourselves

Is health a predictable beneficiary of a country's economic development? Is health of the people a valuable investment for economic growth? How is health related to other areas of development which often seem unconnected and even compete for resources? What are the health priorities that feature in the global development agenda that are relevant to India?

While these questions have been discussed for several decades, greater clarity has emerged in recent years. The prominence of health in the Millennium Development Goals (MDGs: 2000-2015) and in the Sustainable Development Goals (2016-2030), sequentially adopted by the United Nations, arises from the recognition that health is pivotal to equitable and sustainable development and is closely interconnected to other development sectors.

Health status of a population does improve with the country's economic development. As the frequently cited Preston curve shows, life expectancy rises sharply as the average per capita income rises from low levels over time in any country. This benefit tends to plateau at high of per capita income with only small incremental gains of life expectancy, with a further rise in income. However, Kate Pickett and Wilkinson showed that, at similar levels of per capita income, countries with lower levels of income gaps within the population (greater equality) have better life expectancy and other health indicators than countries with higher income gaps within the population (lower equality). In their book *The Spirit Level*, they provide evidence of how even the rich in countries with less equality fare worse than their counterparts in countries with greater equality.

While conventional economic wisdom through a great part of 20th century tended to view health and improved nutrition as passive beneficiaries of economic growth, the latter part of that century recognised population health and nutrition as levers of accelerated economic growth. In his 1993 Nobel Prize lecture, economist Robert Fogel explained how 50 per cent of Britain's economic growth during 1790- 1980 was attributable to improved nutrition, which reflected the social policies adopted during 1790-1930. *The World Development Report* of 1993, titled *Investing in Health*, made a strong case for greater economic investment in health to reap the benefits of greater economic growth.

The author is President, Public Health Foundation of India (PHFI).He edited the National Medical Journal of India for 10 years and is on editorial board of several international and national journals. He has more than 400 scientific publications in international and Indian peer reviewed-journals. His contributions to public health have been recognized through several awards and honourslike WHO Director General's Award for Outstanding Global Leadership in Tobacco Control (World Health Assembly, 2003), Padma Bhushan, 2005, Queen Elizabeth Medal (Royal Society for Health Promotion, UK, 2005).

In late 1990's, the World Health Organisation (WHO) constituted a *Commission on Macroeconomics and Health* which presented evidence on the key contribution of health to economic development. The bidirectional relationship between health and economic development was now firmly established. *The Lancet Commission on Investing in Health* (2013) later projected that low and middle income countries could gain 9 to 20 fold returns on economic investments in health.

The relationships between poverty and health, and education and health are even sharper than those for overall income and health. Poor people are more likely to suffer from a variety of diseases than the rich, with higher rates of maternal and child deaths, undernutrition, infectious diseases, mental illness, injuries, tobacco consumption and exposure to air pollution. Even diseases usually associated with the rich, such as heart diseases, diabetes and cancers become increasingly common among the poor as societies advance economically and a progressive reversal of the social gradient sees these diseases more frequently affecting the poor than the rich, as countries move to the upper middle and high income groups. This is the situation now in USA, Australia and Western Europe, with urban China and urban India also beginning to show a reversal of the social gradient for 'non-communicable' diseases. The poor are more exposed to illness causing agents such as unclean drinking water or tobacco and they lack the protection of good nutrition, have inadequate health information and limited access to health care services, especially because of unaffordable health care costs. A low level of education is particularly a major determinant of poor health status, independent of income.

Illness, in turn, often leads to impoverishment or financial shocks among the economically vulnerable sections (which includes a large segment of the middle class), if most of the health care costs are borne by families as 'out of pocket spending' (OOPS). It is estimated that nearly 100 million persons are pushed in to poverty world over each year by unaffordable expenditure on essential health care. About half of them are Indians. Illness also leads to loss of jobs or earnings, often leads to distress sale of valued possessions and adversely affects the family spending on children's education and nutrition. Similarly, a sick child is unable to fully access the benefits of education, with resultant disadvantage for later employment and income.

The social determinants of health range beyond income and education to include water, sanitation, nutrition, environment, gender, social stability and social status. Policies in agriculture and food systems as well as urban design and transport too profoundly affect health. So does the lack of energy security, especially in India where many women and children are badly affected by indoor air pollution from burning of solid biofuels like wood and dung. Many of these relationships were delineated by the *WHO Commission on Social Determinants of Health* (2005), which recommended that health equity gaps must be bridged within a generation, through determined action on the social determinants of health so that conditions conducive to health are created in all societies. Merely providing equality of opportunity to access health services is not enough, if social deprivation has already created a large lag in health status and limits real and ready access to health services. As British economist Tawney pointed out in his seminal book *Equality*, over 80 years ago, people need "not just an open road, but also an equal start" in a society that promises social justice.

All of these considerations led to the formulation of the MDGs and later the SDGs. There are, however, considerable differences in the vision and values that shaped these two sets of global development goals. The MDGs were principally developed by technocrats assisting the United Nations and were unreservedly adopted by all countries at the euphoric dawn of the new millennium in 2000. They were principally guided by the views of developed countries which vowed to reduce poverty and poverty related diseases and hunger in the low and middle income countries. The targets that were set applied only to low and middle income countries. There was no integrated vision of development and no commitment to multi-sectoral action on many of the social determinants.

Health was directly targeted in three of the eight MDGs, even though others like poverty reduction and education were also clearly related to it. The health MDGs specifically addressed maternal mortality, child mortality and major infectious diseases like HIV-AIDS, TB and Malaria. These were seen as the major public health challenges of the low and middle income countries. The already considerable and rapidly rising burdens of non- communicable diseases, and a major killer like tobacco that killed 100 million in the 20th century, were not considered worthy of inclusion, due to a perverse value judgement that viewed them as ' not the problems of the poor' despite mounting evidence to the contrary.

The three MDGs on health did serve a very useful purpose in mobilising national attention and action on very relevant areas of public health, as well as galvanising global support for targeted actions. They led to the creation of the Global Fund for AIDS, TB and Malaria and funding partnerships for maternal and child survival. However, they fragmented health by disease and segmented it by age. Many major threats to health were missed out, like non-communicable diseases, mental illness and injuries. Older children, adolescents, adult men, non- pregnant women and the elderly were excluded. Only reduction of mortality (death) was considered, while reduction of morbidity (non-fatal illness) and disability did not come into the ambit of MDGs. Most important, these vertical approaches did not take into consideration the need to create strong health systems which could effectively deliver on these promises without neglecting other public health functions. It was not recognised that vertical programmes, however noble in intent and detailed in design, could not be force fitted into weak or dysfunctional health systems. Indeed, they created the risk of disrupting the health system through vertically funded programmes which demanded undivided attention and full dedication

Printed & Published by Dr. Sadhana Rout, [illegible]
C.G.O. Complex, Lodhi Road, New Delhi - 110 003. Printed at Chandu Press, D-97, Shakarpur, [illegible]

from the limited institutional and human resources in low and middle income countries. While aiming for health equity, the MDGs sought to measure only aggregate national indicators, without looking at equity gaps across income, education, rural-urban, gender and other socio-demographic divides within a nation.

The SDGs are a distinct improvement in many ways. First, the text was negotiated through an open and democratic inter-governmental process. Second, the goals are relevant to all countries. The goals cover several domains of development but integrate them within a framework of sustainable development that recognises the linkages. Fourth, environmental protection receives much needed attention, reminding us that the path to economic growth and global development need not and should not be detrimental to planetary health. Fifth, the health SDG corrects the shortcomings of the health MDGs by taking a life course approach to health and emphasising the role of health systems in delivering universal health coverage to promote health equity and provide financial protection against costs of health care.

The lone but lofty health goal of the 17 SDGs calls for "*Healthy Lives for All and Wellbeing At All Ages*". While this sounds a bit vague, it does reflect a universal approach that extends to all people and promotes health in a positive way. The nine targets attached to the health goal are specific in guiding action. They call for: reducing maternal mortality to 70 (per 100,000 live births), under -5 child mortality to 25 and neonatal mortality to 12 (per 1000 live births) by 2030; ending the epidemics of AIDS, Malaria and TB, reducing premature deaths from non-communicable diseases (in the age group 30-70 years), halving deaths from road traffic accidents, reducing substance abuse and harm from air, water and soil pollution. It also calls for universal health coverage, with financial protection and access to essential drugs and vaccines, as well as unimpeded access to reproductive and sexual health services. Further, it calls for effective implementation of the WHO Framework Convention for Tobacco Control.

The relationship of the health goals to the other SDGs is very clear, whether they relate to reduction of poverty, ending hunger, providing universal access to education, promoting gender equity, planned urban growth, providing clean energy, protecting ocean life and forestry, reducing consumption, promoting peace and, most importantly, protecting the planet. The impact of the environment on health is a big concern as air pollution levels mount across the world and chemical pollution also degrades water and soil quality. Climate change, with accelerated global warming, poses public health challenges through heat waves, floods, extreme weather events, spread of vector borne diseases as mosquitos breed at higher altitudes and latitudes, decreased production and nutrient quality of several crops, stress related mental illness and climate related migration. Health is now firmly positioned within this interconnected matrix of development domains. While the indicators for measuring the targets linked to different goals will be adopted in March 2016, countries also need to build capacity for conducting health impact assessment of policies in other sectors.

India signed up to the SDGs in September 2015, at the United Nations. The health agenda set by SDGs is highly relevant to India, as is the broader development agenda. Whether it is continued commitment to the MDG agenda, initiation of effective action on new elements like non-communicable diseases and mental health or earnestly implementing a well planned programme of universal health coverage, India's health priorities resonate well with the SDG targets. We need to gear up the performance of our health system to reach those targets. Equally important, we need to work towards greater policy coherence in harmonising actions across the different development sectors, so that they enable and not erode each other. Only then can we create a healthy future for ourselves. The leap year of 2016 provides a good augury for making a great leap forward on our path to sustainable and equitable development. Health is the best summative indicator of success in all of the SDGs. Let the health of our people be the talisman of our success in this era of sustainable development. ❑

(E-mail: ksrinath.reddy@phfi.org)

Draft Guidelines for Kidney Donors Issued

The National Organ and Tissue Transplant Organisation (NOTTO) under the Ministry of Health & Family Welfare issued draft guidelines for Allocation Criteria for Deceased Donor Kidney Transplant. This will be a major step towards easing rules and procedures to encourage organ donation among the masses. The draft guidelines have been posted on the website of NOTTO- www.notto.nic.in

This initiative will promote organ donation in the country. The guidelines will be finalised after Ministry reviews various suggestions & comments regarding the same"

The draft guidelines include issues like = recipient registration, listing and scoring system in the waiting list scoring system for making priority, allocation principles, allocation algorithm, including criteria for urgent listing, and inter-state issues.

A list of the government and non-government hospitals in Delhi along with those in the neighboring area of the NCR (Gurgaon, Ghaziabad, Faridabad, Noida) have also been listed in the draft guidelines. The hospitals in the NCR cities will be included in the networking along with hospitals of Delhi for the purpose of organ sharing and allocation with the concurrence and MoU with the respective State Governments and institutions in due course of time.